PENNSYLVANIA STATE SYSTEM OF HIGHER EDUCATION

TRANSACTION (TO BE COMPLETED BY HUMAN RESOURCES)

☐ ENROLLMENT ☐ ADD SPOUSE/DEPENDENTS - INDICATE REASON IN REMARKS SECTION ☐ CANCEL COVERAGE ☐ TRANSFER TO AHCP
☐ OPEN ENROLLMENT ☐ REMOVE SPOUSE/DEPENDENTS - INDICATE REASON IN REMARKS SECTION ☐ CHANGE – INDICATE REASON IN REMARKS SECTION

☐ ACTIVE GROUP HEALTH PROGRAM ☐ ANNUITANT HEALTH CARE PROGRAM	GROUP #	BARGAINING UNIT	PERSONNEL #	EMP/ANN PREMIUM	EFFECTIVE DATE

EMPLOYEE DEMOGRAPHIC INFORMATION (TO BE COMPLETED BY EMPLOYEE)

HEALTH PLAN CHOICES:	MANAGEMENT BENEFITS (DENTAL, VISION, HEARING – not applicable to Faculty
☐ INDEMNITY (closed to new enrollments) ☐ PPO PLAN ☐ HEALTH MAINTENANCE ORGANIZATION (HMO) ☐ WAIVE MEDICAL BENEFITS	☐ MANAGEMENT BENEFITS ☐ MANAGEMENT BENEFITS **ONLY** ☐ WAIVE MANAGEMENT BENEFITS

☐ FULL-TIME EMPLOYEE ☐ PART-TIME EMPLOYEE	HMO NAME	HMO PRIMARY CARE PHYSICIAN (PCP) PRACTICE NAME	HMO ID#

SOCIAL SECURITY #	**EMPLOYEE NAME**	**DATE OF BIRTH (MM,DD,YYYY)**

STREET ADDRESS	**CITY**	**STATE**	**ZIP CODE**

COUNTY	**RELATIONSHIP STATUS** ☐ **SINGLE** ☐ **MARRIED** ☐**DIVORCED** ☐ **SAME-SEX DOMESTIC PARTNER**	**DATE OF MARRIAGE/ DOM. PARTNERSHIP**	**DATE OF DIVORCE/ TERM OF DOM.PARTNERSHIP**	**DAYTIME PHONE #**

DEPENDENT DATA (TO BE COMPLETED BY EMPLOYEE)

ELIGIBILITY DOC. VERIFIED	ADD/REMOVE	DEPENDENT NAME	DATE OF BIRTH (MM,DD,YYYY)	SOCIAL SECURITY #	(HMO) PCP PRACTICE NAME AND ID# (if different than employee)
☐	☐ ☐	SPOUSE/DOMESTIC PARTNER			
☐	☐ ☐	SON ☐ DAU ☐ OTHER ☐ (Explain Relationship)			
☐	☐ ☐	SON ☐ DAU ☐ OTHER ☐ (Explain Relationship)			
☐	☐ ☐	SON ☐ DAU ☐ OTHER ☐ (Explain Relationship)			
☐	☐ ☐	SON ☐ DAU ☐ OTHER ☐ (Explain Relationship)			

OTHER COVERAGE DATA

Does your spouse/Domestic Partner have other State System of Higher Education health 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	MEDICARE INS. #
PART A EFF. DATE	PART B EFF. DATE
DEPENDENT NAME	MEDICARE INS. #
PART A EFF. DATE	PART B EFF. DATE

REMARKS:

AUTHORIZATION FOR APPLICATION FOR ENROLLMENT: I request the above enrollment (or change) for insurance coverage and authorize the PA State System to make pre-tax payroll deductions or deductions from my annuity if applicable. I hereby apply for the coverage indicated. ***I understand no changes can be made to this coverage except during Open Enrollment, or when a qualified life event occurs.*** I also 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 who 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. ***I understand that I may be personally liable for any claims paid on behalf of an ineligible dependent.***

EMPLOYEE/ANNUITANT SIGNATURE	DATE (MM.DD.YYYY)	HUMAN RESOURCES USE ONLY (FULL CLOCK #)

The following categories of individuals may be eligible for coverage under the PASSHE health plan for active employees:

- Legal Spouse
- Same-sex domestic partner (applicable to Faculty, non-faculty Coaches and non-represented employees)
- Children under 26 years of age who are not eligible for coverage within their own employer's health plan, or within their spouse's health plan if married, and who meets one of the following requirements:
  - A natural child of your own
  - A legally adopted child (including a child living with the employee during the probation period)
  - A stepchild
  - A child for whom the employee is the legal guardian
  - A foster child, if the employee was the child's legal guardian, or foster parent prior to the child's 18th birthday (foster children under age 18 are not eligible dependents)
  - A child being supported by the employee under a court order as a result of a divorce decree
  - A newborn child of an employee from the moment of birth to a maximum of 31 days from date of birth. To be covered as a Dependent beyond the 31-day period, the newborn child must be added as a Dependent through the System university office.
  - Unmarried dependent child 26 years of age or older, who is incapable of self-support because of a physical or mental disability that commenced before the age of 26
  - A child of a Domestic Partner (applicable to Faculty, non-faculty Coaches and non-represented employees)

When Can I Make Changes To My Covered Dependents?

Outside of open enrollment, if you experience a qualifying life event you may have the opportunity to add or remove dependents from your coverage, or make other changes to your benefit elections. You will need to notify your Human Resources office within **60 days** of the event occurring. Below are some of the more common examples.

- **Removing Dependents**

  You are required to contact your Human Resources office and remove a dependent who is no longer eligible for PASSHE coverage under the following situations:
  - Covered child becomes eligible for coverage under their own (or their spouse's) employer's health plan
  - Covered child attains age 26 (unless disabled)
  - Divorce (removal of spouse and stepchildren)
  - Termination of a domestic partnership (removal of partner and children of partner)
  - Death of a dependent

- **Adding Eligible Dependents**

  You may add a dependent for PASSHE health coverage due to a qualifying life event. You must notify your Human Resources office and submit the enrollment change within **60 days** of the qualifying life event.
  - You gain a dependent through birth or adoption
  - You get married or enter into a qualifying domestic partnership
  - Your dependent loses coverage under another employer's plan
  - Your dependent loses eligibility for coverage in a Medicare plan, a Medicaid plan or a state children's health insurance program

- **Other Plan Enrollment Changes**

  You must notify your Human Resources office and submit the enrollment change within **60 days** of the qualifying life event.
  - You lose coverage under your spouse's plan
  - You move, either to an area outside of your current plan's service area, or to an area where a different plan option is available
  - You are enrolled in a plan option that is no longer available, or is substantially reduced