EMPLOYEE ENROLLMENT/CHANGE FORM

Important: Changes made on this form will affect your medical, prescription drug, and supplemental benefits.

SECTION 1: EMPLOYEE DATA

Social Security #	Name (Last Plus Suffix, First, MI)	Employee #
Street Address		Local Municipality (if address change)
City/State/Zip		County Name
Mailing Address (if different than address listed above)		City/State/Zip

Home Phone #	Cell Phone #	Work Phone #	Date of Birth (mm/dd/yyyy)	Gender ☐ Male ☐ Female ☐ Undeclared
Relationship Status ☐ Single ☐ Married ☐ Common Law		Date of Marriage (mm/dd/yyyy)		

Answer both of the following questions:

Are you covered by another medical plan? ☐ Yes ☐ No Do you have Medicare? ☐ Yes ☐ No

SECTION 2: ENROLLMENT INFORMATION

a) Action Requested (select all that apply):

☐ New Enrollment ☐ Add/Remove Dependent(s) ☐ Plan Change ☐ Dependent Data Change/Correction

☐ Open Enrollment (effective January 1 of next calendar year)

b) Event (select all that apply):

☐ Marriage ☐ Birth/adoption of child ☐ Divorce ☐ Death ☐ Termination of Benefits

☐ Address Change ☐ Other (Reason): _____

c) Date of Event: *(if applicable)* (mm/dd/yyyy)

_____

SECTION 3: MEDICAL BENEFITS *(Select one)*

Full-Time Employees: Additional costs may apply if selecting the CHOICE PPO.
Part-Time Employees: Additional costs will apply for any plan selection.

☐ CHOICE PPO ☐ BASIC PPO ☐ PEBTF CUSTOM HMO

☐ Decline ☐ Bronze (only available if you have been notified that you are eligible) **Effective Date** (mm/dd/yyyy)**:** _____

Medical Plan Name	Health Care Center or Dr. Name (required for HMO)	Health Care Ctr/Provider ID #
	Are you currently a patient of this practice? ☐ Yes ☐ No	

SECTION 4: PRESCRIPTION DRUG BENEFITS

If enrolling in prescription drug plan only, also complete the PEBTF-41 form

Full-Time Employees: Additional costs will apply for the first 90 days of employment.
Part-Time Employees: Additional costs will apply.

☐ Decline ☐ Enroll **Effective Date** (mm/dd/yyyy)**:** _____

SECTION 5: SUPPLEMENTAL BENEFITS *(Includes dental, vision and hearing aid coverage)*

Supplemental Benefits will begin no earlier than after 90 days of employment.
Part-Time Employees: Additional costs will apply.

☐ Decline ☐ Enroll **Effective Date** (mm/dd/yyyy)**:** _____

SECTION 6: SPOUSE DATA

Complete this section if adding or removing a spouse. If adding a new spouse, you must present your original marriage certificate to your local HR office or your supervisor.

HR initial Eligibility Doc Verified	Name (Last, First, MI)	Spouse SSN	Gender	Date of Birth (mm/dd/yyyy)
			☐ Male ☐ Female ☐ Undeclared	

List address and telephone number if different than the employee:

1. Does your spouse have Medicare?
   ☐ Yes ☐ No
2. Is your spouse covered by another medical plan?
   ☐ Yes ☐ No
3. My spouse is currently (Select One):
   ☐ A Commonwealth of Pennsylvania employee or retiree
   ☐ Employed, either Full-Time or Part-Time, or Retired (answer questions 4, 5 and 6)
   ☐ Not Employed or Self-Employed (do not answer remaining questions)
4. Is your spouse eligible for health coverage through his or her employer or former employer?
   ☐ Yes
   ☐ No
5. Is your spouse enrolled in his/her employer's health insurance or enrolled in a retiree health insurance plan?
   ☐ Yes A copy of your spouse's medical ID card must be submitted with this form.
      a) Is the plan offered at a cost? ☐ Yes ☐ No
      b) Is there a monetary incentive to decline coverage? ☐ Yes ☐ No
   ☐ No
   ☐ Not applicable
6. Does your spouse have an HSA (Health Savings Account)? ☐ Yes ☐ No ☐ Not applicable
   (There may be tax implications if he or she enrolls in a PEBTF plan as secondary.)

	Add	Remove	Effective date (mm/dd/yyyy)	
Medical plan	☐	☐		Health Care Center/Doctor Name (required for HMO) Health Care Ctr/Provider ID # Currently a patient of this practice? ☐ Yes ☐ No
Prescription drug plan *If enrolling in prescription drug plan only, also complete the PEBTF-41 form*	☐	☐		**Remarks:**
Supplemental benefits (dental/vision/hearing aid plans)	☐	☐		
Personal data change/correction: identify in Remarks				

(Form continues next page)

SECTION 7: DEPENDENT DATA *(Complete second form if you have additional dependents)*

Complete this section if adding or removing dependents. If adding a new dependent, you must present additional documentation such as a birth certificate to your local HR office or your supervisor.

Eligibility Verified by HR	Name (Last, First, MI)	Dependent SSN	Gender	Date of Birth (mm/dd/yyyy)
			☐ Male ☐ Female ☐ Undeclared	

☐ Son ☐ Daughter ☐ Other, explain relationship:

List address and telephone number if different than the employee:

a) Does your dependent have Medicare? ☐ Yes ☐ No

b) Is your dependent covered by another plan? ☐ Yes ☐ No

	Add	Remove	Effective date (mm/dd/yyyy)	
Medical plan	☐	☐		Health Care Center/Doctor Name (required for HMO) Health Care Ctr/Provider ID # Currently a patient of this practice? ☐ Yes ☐ No
Prescription drug plan *If enrolling in prescription drug plan only, also complete the PEBTF-41 form*	☐	☐		**Remarks:**
Supplemental benefits (dental/vision/hearing aid plans)	☐	☐		
Personal data change/correction: identify in Remarks				

Eligibility Verified by HR	Name (Last, First, MI)	Dependent SSN	Gender	Date of Birth (mm/dd/yyyy)
			☐ Male ☐ Female ☐ Undeclared	

☐ Son ☐ Daughter ☐ Other, explain relationship:

List address and telephone number if different than the employee:

a) Does your dependent have Medicare? ☐ Yes ☐ No

b) Is your dependent covered by another plan? ☐ Yes ☐ No

	Add	Remove	Effective date (mm/dd/yyyy)	
Medical plan	☐	☐		Health Care Center/Doctor Name (required for HMO) Health Care Ctr/Provider ID # Currently a patient of this practice? ☐ Yes ☐ No
Prescription drug plan *If enrolling in prescription drug plan only, also complete the PEBTF-41 form*	☐	☐		**Remarks:**
Supplemental benefits (dental/vision/hearing aid plans)	☐	☐		
Personal data change/correction: identify in Remarks				

TERMS AND CONDITIONS

1. I hereby apply to enroll (or change) medical and/or prescription drug, and/or supplemental benefits in the Pennsylvania Employees Benefit Trust Fund ("Plan") for me and/or my dependents (as defined in the Plan) and declare that the foregoing information is true and correct to the best of my knowledge and belief. I understand that eligibility for coverage and payment of benefits under the Plan in all instances is subject to the terms of the Plan and that any false or misleading information that I provide to the Plan regarding the status of any dependent and any other medical or supplemental coverage that may be applicable may result in the suspension or termination of coverage under the Plan and may require the repayment to the Plan of any benefits paid under the Plan, in addition to the imposition of criminal and civil penalties. I understand that I must inform the Plan of any changes in the employment status of any dependents which may affect their eligibility under the Plan and that my failure to do so may result in the loss of coverage, repayment of any amounts paid on their behalf, in addition to the imposition of criminal and civil penalties.

2. I authorize any payroll deduction relating to my share of the cost of such coverage and understand that such deductions will be made on a pre-tax basis to the extent permitted by law.

3. I further understand that the Plan has the right to subrogate, on my behalf and on behalf of any dependent, against any third parties or others obligated to pay any claims which the Plan has paid or may pay. I agree that I will direct any attorney that I may retain to satisfy such subrogation interest in full prior to receipt by me or my dependents of any recovery to which I and/or my dependents may be entitled and to otherwise fully cooperate with the Plan regarding all subrogation matters.

4. I further understand that the Plan includes a coordination of benefits provision and agree to fully cooperate with the Plan regarding all coordination of benefit matters. I acknowledge that in the event the Plan concludes that I have provided any false or misleading information, or failed to appropriately cooperate with the Plan, regarding any subrogation or coordination of benefit matters, the Plan may suspend or terminate my coverage or my dependents' coverage under the Plan and take such other action as it deems appropriate.

SECTION 8 : EMPLOYEE AGREEMENT AND SIGNATURE

"I certify that the information entered on this form is true and complete and that I agree to all of the Terms and Conditions listed above and in the PEBTF Summary Plan Description and Plan Document."

Employee Name	Employee Signature	Date

Form must be signed in ink. Electronic signatures will not be accepted.

SECTION 9: COMMONWEALTH DATA *(to be completed by HR Service Center or HR Office)*

Position #	PEBTF Group #	PEBTF Sub Group	Plan Code	County Code	
Current Service Date	Dept. Code	Barg. Unit	Org Code	SAP EEG	SAP ESG

Is employee ACA eligible for the Bronze Plan (works average of 30 hours per week)? ☐ Yes ☐ No

SECTION 10: HR REMARKS

HR Service Center or HR Office Signature	Date Enrollment Form Received	Date Enrollment Form Processed