

Retired Employees Health Program - Annuitant Enrollment Form

1. Annuitant Account Data

Title: <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Dr. <input type="checkbox"/> Ms.		Name (Last, First, MI)		Gender (M/F)	
Street Address			City	State	Zip Code
County Name			Home Telephone Number () ()	Alternate Telephone Number () ()	
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Domestic Partner (DP)			Date of Marriage / DP		Date of Divorce / Termination of DP
Does your Spouse or Domestic Partner have other Commonwealth Health Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, List Spouse/DP's SSN _____ - _____					
Note: There can be no duplication of coverage. Do not list Spouse/DP below if already enrolled in PEBTF's health program for commonwealth employees, or the REHP!					

2. Annuitant / Dependent Enrollment Data

Relationship	Annuitant	<input type="checkbox"/> Domestic Partner <input type="checkbox"/> Spouse	<input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other	<input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other
Name (Last, First, MI)	Completed Above			
Date of Birth (mm,dd,yyyy)				
Gender (Indicate Male or Female)				
Social Security Number				
Medicare Number				
Medicare Dates (mm,dd,yyyy) (If Medicare eligible)	Part A: Part B:	Part A: Part B:	Part A: Part B:	Part A: Part B:
Non Medicare Plan Option	<input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> CDHP	<input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> CDHP	<input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> CDHP	<input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> CDHP
Medicare Plan Option	<input type="checkbox"/> MHMO <input type="checkbox"/> MPPO	<input type="checkbox"/> MHMO <input type="checkbox"/> MPPO	<input type="checkbox"/> MHMO <input type="checkbox"/> MPPO	<input type="checkbox"/> MHMO <input type="checkbox"/> MPPO
Health Care Plan Name**				
Health Care Center** Doctor's Name** Doctor's ID# ** ** if electing HMO, or MHMO				
Plan Code / Coverage Code	/	/	/	/
Dependent address if different from member				

3. List other medical coverage for enrollees

Note: If the retiree is enrolling dependents who were not previously enrolled under retiree's active commonwealth coverage, or in the REHP, they must complete Form PEBTF-2a - Coordination of Benefits Form.

4. Commonwealth Data

Your monthly share amount	\$ _____	Effective Date	Final Annual Salary	Bargaining Unit	Years of Service
PPO Buy-Up fee	\$ _____	State Share <input type="checkbox"/> Fully State Paid <input type="checkbox"/> Majority State Paid <input type="checkbox"/> \$5.00 Deduction	Department Retired From		
Total amount due	\$ _____				
Amount deducted from pension	\$ _____	Group Number 919	Retirement Type		
Amount PEBTF will bill you	\$ _____				

Comments:

Authorization for application for enrollment - I hereby apply for enrollment in or make a change to my health care coverage and authorize deductions from my annuity, if applicable for my share of the cost of coverage. I understand this application is subject to approval by the Program. As a condition to receiving health care coverage under the Program, I hereby agree that the Program (1) shall have all legal rights of subrogation on my behalf and/or my dependents to pursue recovery against third parties for the amount of any benefit payments, and (2) shall have the right to reimbursement from me or my dependents for the amount of any benefit payments if I or my dependent receives any recovery from a third party regardless of the amount of a recovery or any allocation or no allocation of a recovery amount for medical expenses. I further agree that I will direct any attorney that I may retain to satisfy such subrogation or reimbursement interest in full and as a first priority prior to the distribution of any recovery to me or my dependents. I agree that any information or records requested by the Program to pursue its subrogation or reimbursement claim will be promptly provided by me and/or my dependents. I further understand that if I or my dependents fail to cooperate to provide accurate information or any documents required for release of any such information to the Program, I and/or my dependents may be required to repay the amount of any benefit payments and I and my dependents will be subject to disqualification from the Program. I understand that if I provide any false or misleading information to the Program, I, along with my dependents, may be disqualified from the receipt of future benefits and subject to prosecution under applicable federal and state criminal and civil statutes, which may result in penalties including monetary fines and/or imprisonment. Finally, I understand the information on this form may be used by the Commonwealth of Pennsylvania and the Program or PEBTF for such administrative and actuarial purposes as they deem appropriate.

Signature _____

Date _____

SERS Authorization _____