

Retired Employees Health Program - Annuitant Change Form

1. Annuitant Demographics

Title: <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Dr. <input type="checkbox"/> Ms.	Name (Last, First, Mi)	Home Telephone # ()
Street Address		Alternate Telephone # ()
City	State	Zip Code
		County Name

Make the following change(s) to the annuitant's health benefits record (check and complete all that apply)

<input type="checkbox"/> Change address as shown above <input type="checkbox"/> Remove dependent(s) shown below (include effective date and reason) <input type="checkbox"/> Add dependent(s) shown below (include effective date and reason) <input type="checkbox"/> Change medical plan(s) (include effective date and reason) <input type="checkbox"/> Check if change during open enrollment <input type="checkbox"/> Other – explain in comments section	<input type="checkbox"/> Opt-Out <input type="checkbox"/> Member – total coverage <input type="checkbox"/> Member – medical coverage <input type="checkbox"/> Member – Rx coverage <input type="checkbox"/> Dependent(s) – total coverage <input type="checkbox"/> Dependent(s) – medical coverage <input type="checkbox"/> Dependent(s) – Rx coverage <input type="checkbox"/> Opt-In <input type="checkbox"/> Member – total coverage <input type="checkbox"/> Member – medical coverage <input type="checkbox"/> Dependent(s) – total coverage <input type="checkbox"/> Dependent(s) – medical coverage	Note: You may elect medical coverage only if you are Medicare eligible and enrolled in PACE/PACENET, Tricare or VA prescription drug coverage and you provide a copy of your ID card.
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Effective date of change(s):	Reason for change(s):
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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) (Required 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				

Complete address when removing COBRA eligible dependent(s)			
Street	City	State	ZIP

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
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Return this form to: SERS - Health Benefits Section, 4TH Floor, 30 N. 3rd St., Suite 150, Harrisburg, PA 17101