



COBRA Enrollment/Change Form

Qualifying life events – form must be returned within **60 days of event.**
(see link below or [click here](#) for qualifying events information)

CHANGE REASON(S)					
<input type="checkbox"/> ADD SPOUSE/DEPENDENTS - INDICATE REASON IN REMARKS SECTION		<input type="checkbox"/> CANCEL COVERAGE			
<input type="checkbox"/> REMOVE SPOUSE/DEPENDENTS - INDICATE REASON IN REMARKS SECTION		<input type="checkbox"/> CHANGE – INDICATE REASON IN REMARKS SECTION			
COBRA OPEN ENROLLMENT	GROUP #	BARGAINING UNIT	PERSONNEL #	EFFECTIVE DATE 7/1/2023	
EMPLOYEE DEMOGRAPHIC INFORMATION					
HEALTH PLAN CHOICES:			SUPPLEMENTAL BENEFITS (DENTAL and VISION – not applicable to Faculty)		
<input type="checkbox"/> PPO PLAN <input type="checkbox"/> UPMC (Changes to current participants only, no new enrollments) <input type="checkbox"/> WAIVE MEDICAL BENEFITS			<input type="checkbox"/> SUPPLEMENTAL BENEFITS <input type="checkbox"/> WAIVE SUPPLEMENTAL BENEFITS		
SOCIAL SECURITY #	EMPLOYEE NAME			DATE OF BIRTH (MM/DD/YYYY)	
STREET ADDRESS		CITY		STATE	ZIP CODE
COUNTY	RELATIONSHIP STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> SAME-SEX DOMESTIC PARTNER	DATE OF MARRIAGE/ DOM. PARTNERSHIP	DATE OF DIVORCE/ TERM OF DOM.PARTNERSHIP	DAYTIME PHONE #	
DEPENDENT DATA					
ADD/REMOVE	DEPENDENT NAME		DATE OF BIRTH (MM/DD/YYYY)	SOCIAL SECURITY #	
<input type="checkbox"/> <input type="checkbox"/>	SPOUSE <input type="checkbox"/> DOMESTIC PARTNER <input type="checkbox"/> Name: _____ Gender: _____				
<input type="checkbox"/> <input type="checkbox"/>	SON <input type="checkbox"/> DAU <input type="checkbox"/> OTHER <input type="checkbox"/> (Explain Relationship) Name: _____ Gender: _____				
<input type="checkbox"/> <input type="checkbox"/>	SON <input type="checkbox"/> DAU <input type="checkbox"/> OTHER <input type="checkbox"/> (Explain Relationship) Name: _____ Gender: _____				
<input type="checkbox"/> <input type="checkbox"/>	SON <input type="checkbox"/> DAU <input type="checkbox"/> OTHER <input type="checkbox"/> (Explain Relationship) Name: _____ Gender: _____				
<input type="checkbox"/> <input type="checkbox"/>	SON <input type="checkbox"/> DAU <input type="checkbox"/> OTHER <input type="checkbox"/> (Explain Relationship) Name: _____ Gender: _____				
OTHER COVERAGE DATA					
Does your spouse/Domestic Partner have other State System of Higher Education health coverage?					
<input type="checkbox"/> YES <input type="checkbox"/> NO					
Do you or your dependents have other health coverage?					
<input type="checkbox"/> YES <input type="checkbox"/> NO If yes, provide the following information:					
Full Name of Insured	Name of Health Care Plan/Insurance Co.		Policy/ID Number		
REMARKS:					
AUTHORIZATION FOR APPLICATION FOR ENROLLMENT: I request the above enrollment (or change) for insurance coverage. 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			DATE (MM/DD/YYYY)	HUMAN RESOURCES USE ONLY (FULL CLOCK #)	

Dependent eligibility documents - http://www.passhe.edu/inside/hr/syshr/Benefit_Summaries/SSHE_Summary.pdf#page=14

Qualifying Event Information - http://www.passhe.edu/inside/hr/syshr/Benefit_Summaries/SSHE_Summary.pdf#page=17